State of Connecticut
Department of Public Health
Facility Licensing and Investigations Section

IN RE: Priority Care, Inc. d/b/a Patient Care of New Haven
1 Church Street, 5th Floor
New Haven, CT 06510-3342

MODIFIED CONSENT AGREEMENT

WHEREAS, Priority Care, Inc. d/b/a Patient Care of New Haven (hereinafter the "Licensee"), has been issued License No. C9714105 to operate a Home Health Care Agency (hereinafter the "Facility") under Connecticut General Statutes Section 19a-490, by the Department of Public Health (hereinafter the "Department"); and

WHEREAS, the Licensee has a Consent Agreement with the Department which became effective July 26, 2004, of which is attached hereto (Exhibit A); and

WHEREAS, the Department's Facility Licensing and Investigations Section ("FLIS") conducted unannounced inspections at the Facility for the purposes of conducting a survey inspection and violations of the Regulations of Connecticut State Agencies were identified in a violation letter dated November 18, 2005 (Exhibit B); and

WHEREAS, an office conference regarding the November 18, 2005 violation letter was held between the Department and the Licensee on December 5, 2005; and

WHEREAS, the Licensee and the Department have agreed to modify the aforementioned Consent Agreement; and

WHEREAS, it is expressly understood that the execution of this Consent Agreement, and any statements or discussions leading to the execution of the Consent Agreement, shall not be

be construed to constitute any admission or adjudication of any violation of the Regulations of Connecticut State Agencies and/or Connecticut General Statutes by the Licensee, its officers, directors, agents, employees, or any other person or entity in any subsequent matter, proceeding, hearing or lawsuit.

NOW THEREFORE, the Facility Licensing and Investigations Section of the Department of Public Health of the State of Connecticut, acting herein by and through Joan D. Leavitt, its Section Chief, and the Licensee, acting herein by Robert J. Nixon, its President and CEO, hereby stipulate and agree as follows:

1. The Consent Agreement executed with the Department on July 26, 2004 shall be incorporated and made part of this Modified Consent Agreement.
2. Effective upon execution of this Modified Consent Agreement and in accordance with the provisions set forth in Section 8 of Exhibit A, the Licensee shall within thirty (30) days of the execution of the Modified Consent Agreement, develop or revise, as necessary, all policies and procedures relating to wound care and management, pain assessment and management, nutritional and hydration status and mental/emotional status.
3. The Licensee shall within thirty (30) days of the execution of this Modified Consent Agreement add to the Licensee's current program a component to evaluate the clinical competency of all professional direct service staff. The Supervisor of Clinical Services and/or qualified clinical designee shall conduct joint home visits with each primary care nurse (PCN) to assess clinical competence and to initiate a program of remediation, if appropriate. Joint home visits shall be scheduled at least quarterly for those PCNs who work 25-40 hours per week or average twenty-five (25) or more visits weekly on a per diem basis. Two (2) joint visits shall be conducted by a qualified Supervisor of Clinical Services and two (2) visits by a RN clinical designee with at least two (2) years of home care experience. Nurses who work less than full time or average less than twenty-five (25) visits weekly on a per diem basis shall have two (2) joint visits per year, one of

which will be conducted by the Supervisor of Clinical Services and one (1) by a RN clinical designee with at least two (2) years of home care experience. Nurses who work three (3) visits or fewer per week shall have one (1) RN clinical field supervision per year as per state regulations conducted by the Supervisor of Clinical Services or by a qualified RN clinical designee with at least two (2) years of home care experience. The purpose of said oversight and reviews shall be to assess clinical competence and to initiate a program of remediation, as applicable. At least annually, one (1) joint home visit shall include supervision of the home health aide.

4. The Supervisor of Clinical Services shall oversee the preparation of a report regarding the reviews and outcomes that will be approved by the Administrator and presented to the Professional Advisory Committee at its meetings. Said reports shall be available for review by the Department for a period of two (2) years.
5. The Licensee shall within forty-five (45) days of the execution of this Modified Consent Agreement, develop and implement a program to assess staff compliance with the Licensee's policies, procedures and standards of practices. The program shall include but not be limited to a mechanism whereby remediation of staff occurs for failure to adhere to facility policy and procedures.
6. The Licensee shall within sixty (60) of the execution of this Modified Consent Agreement, develop and implement an additional orientation and mentoring program for newly employed direct care professional staff. Said program shall include, but not be limited to policies, procedures, practices, assessment, individualized care planning, coordination and monitoring; a mentoring program shall be developed to include but not be limited to establishment of individual competency, remediation if necessary and follow-up supervision by the Supervisor of Clinical Services/Therapy Supervisor for the period of mentoring. A record of new employee attendance at all didactic sessions shall be maintained for Department review for a period of two years.
7. The Licensee shall contract at its own expense with a registered nurse acceptable to the Department to serve as an Independent Nurse Consultant (INC) for a minimum of three

(3) months. The Department shall review the necessity of continuing the Independent Nurse Consultant at the end of the three (3) months time frame. The INC shall be at the facility twenty (20) hours a week. The Independent Nurse Consultant shall have fiduciary responsibility to the Department and shall perform said functions in accordance with FLIS' Independent Nurse Consultant Guidelines (Exhibit C – copy attached). The responsibilities of the INC shall include monitoring of care and services provided to patients and/or remediation of staff when potential care issues are identified. The Independent Nurse Consultant shall have the responsibility for:

i. Assessing, monitoring and evaluating the delivery of direct patient care and therapies with particular emphasis and focus on the delivery of nursing services by registered, licensed practical nurses and ancillary staff;
ii. Recommending to the Licensee and the Department an increase in the Independent Nurse Consultant's monitoring hours if unable to fulfill the responsibilities within the stipulated twenty (20) hours per week;
iii. Review of patient care policies and procedures relative to monitoring, assessing and development of individual plans of care;
iv. Assessing, monitoring and evaluating the coordination of patient care with all entities involve in the plan of care; and
v. Assessing, monitoring and evaluating the on-going clinical supervision of the agency's caseload and staff.

8. The Department shall retain the authority to extend the period the Independent Nurse Consultant functions are required, should the Department determine that the Licensee is not able to maintain substantial compliance with federal and state laws and regulations.
9. Any records maintained in accordance with any state or federal law or regulation or as required by this Modified Consent Agreement shall be made available to the Independent Nurse Consultant and the Department, upon their request.

10. The Independent Nurse Consultant and the Licensee or a designee of the Governing Authority shall meet with the Department every four (4) weeks for the period of time the INC is at the Facility.
11. The Independent Nurse Consultant shall submit biweekly reports to the Department to address the facility's initiative to comply with applicable federal and state statutes and regulations and the assessments of the care and services provided to patients receiving services from the agency.
12. The Licensee upon the execution of the Modified Consent Agreement shall pay a financial penalty of one thousand dollars ($1,000.00). Said payment shall be received by the Department of Public Health no later than two (2) weeks after the effective date of this Agreement. The check will be made payable to the Treasurer of the State of Connecticut.
13. The financial penalty and any other reports and meetings required by this document shall be sent to:

    Victoria V. Carlson, R.N., M.B.A.
    Supervising Nurse Consultant
    Department of Public Health
    Facility Licensing and Investigation Section
    410 Capitol Avenue, MS #12HSR
    P.O. Box 340308
    Hartford, CT 06134-0308

14. All parties agree that this Modified Consent Agreement is an order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of this Agreement or of any statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, or any other administrative and judicial relief provided by law. This Modified Consent Agreement may be admitted by the Department as evidence in any

proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.

15. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the DCJ's Statewide Prosecution Bureau.
16. The terms of this Modified Consent Agreement and the Agreement executed on July 26, 2004, shall remain in effect for a period of two (2) years from the effective date of this document. After this Modified Consent Agreement has been if effect for one (1) year, Licensee may request that the Department agree to terminate the Modified Consent Agreement and the Agreement executed on July 26, 2004 prior to the end of the two-year term.
17. The Licensee understands that this Modified Consent Agreement and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.
18. The Licensee had the opportunity to consult with an attorney prior to signing this document.

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IN WITNESS WHEREOF, the parties hereto have caused this Modified Consent Agreement to be executed by their respective officers and officials, which Modified Consent Agreement is to be effective as of the later of the two dates noted below.

PRIORITY CARE, INC. D/B/A PATIENT CARE OF NEW HAVEN - LICENSEE

April 19, 2006
Date

By: _____
Robert J. Nixon, President and CEO

State of Connecticut)
County of _____ ss _____ 2006

Personally appeared the above named Robert J. Nixon and made oath to the truth of the statements contained herein.

My Commission Expires: April 6, 2010

MORELLA JOSEPH
NOTARY PUBLIC OF NEW JERSEY
MY COMMISSION EXPIRES APRIL 6, 2010

Morella Joseph
Notary Public [✓]
Justice of the Peace [ ]
Town Clerk [ ]
Commissioner of the Superior Court [ ]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

4/27/06
Date

By: _____
Joan D. Leavitt, R.N., M.S., Section Chief
Facility Licensing and Investigations Section

EXHIBIT A

State of Connecticut
Department of Public Health
Division of Health Systems Regulation

IN RE: Priority Care, Inc.
1 Church Street, 5th Floor
New Haven, CT 06511

CONSENT AGREEMENT

WHEREAS, Priority Care, Inc. of New Haven, CT ("Licensee"), has been issued License No. C9714105 to operate a Home Health Care Agency under Connecticut General Statutes 19a-490 by the Department of Public Health (the "Department"); and

WHEREAS, the Division of Health Systems Regulation ("DHSR") of the Department conducted unannounced inspections on various dates commencing on January 9, 2004 up to and including February 13, 2004 for the purpose of conducting a certification inspection; and

WHEREAS, the Department during the course of the aforementioned inspections identified violations of Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated February 26, 2004 (Exhibit A – copy attached); and

WHEREAS, the foregoing acts constitute grounds for disciplinary action pursuant to section 19a-494 of the General Statutes of Connecticut, taken in conjunction with sections 19a-13-D66 et seq. of the Regulations; and,

WHEREAS, the parties desire to fully resolve the matter without further proceeding; and,

WHEREAS, the Licensee, in consideration of this Consent Agreement, has chosen not to contest the above allegations before a hearing officer and further agrees that this Consent Agreement shall have the same effect as if ordered after a full hearing pursuant to section 19a-494 of the General Statutes of Connecticut; and,

WHEREAS, it is expressly understood that the execution of this Consent Agreement, and any statements or discussions leading to the execution of the Consent Agreement, shall not be construed to constitute any admission or adjudication of any violation of the Regulations of Connecticut State Agencies and/or Connecticut General Statute by the Licensee, its officers, directors, agents, employees, or any other person or entity in any subsequent matter, proceeding, hearing or lawsuit.

NOW THEREFORE, the Division of Health Systems Regulation of the Department of Public Health of the State of Connecticut acting herein and through Marianne Horn, its Director, and the Licensee, acting herein through Arthur Stratton, its President, hereby stipulate and agree as follows:

1. The Licensee understands and agrees this Consent Agreement shall be admissible as evidence in any subsequent proceeding before the Department in which the Licensee's compliance with this same Consent Agreement is at issue; and
2. The Licensee understands that this Consent Agreement fully and completely resolves the allegations referenced above without any further proceeding before the Department; and
3. The Licensee waives the right to a hearing on the merits of this matter; and
4. The Licensee understands this Consent Agreement is a matter of public record; and
5. The Licensee within seven (7) days of the execution of this Consent Agreement shall designate an individual within the Facility who has

responsibility for the implementation of this Consent Agreement. The assigned individual shall submit monthly reports to the Department regarding the provisions contained within this document; and

6. Effective upon execution of this Consent Agreement, the Licensee through its Governing Body, Administrator and Supervisor of Clinical Services shall ensure that:
    a. Each agency Patient Service Office shall be staffed with the appropriate number of full-time supervisors of clinical services;
    b. Each patient's personal physician or covering physician is notified in a timely manner of any significant change in condition;
    c. All care provided to patients by licensed practical nurses is coordinated by and under the direction and supervision of a registered nurse;
    d. All patients are re-evaluated in a comprehensive manner as often as necessary depending on the condition of the patient;
    e. All patients shall have a comprehensive plan of care developed and/or revised which is based on the individual patient's assessment and/or re-assessment and is reflective of the needs of the patient;
    f. All services provided to patients will be coordinated to support the goals and objectives outlined in the plan of care and in accordance with the written plan of care.
7. The Licensee shall within thirty (30) days of the effective date of this Consent Agreement review and revise, as necessary, each patient's plan of care based upon the patient's current and ongoing assessments. Said care plan shall identify each individual patient's problems, needs and goals in accordance with federal and state laws and regulations.

8. The Licensee shall within twenty one (21) days of the effective date of this Consent Agreement review and revise as necessary all policies and procedures which are pertinent to patient assessment, development and implementation of the plan of care, coordination of care and services and notification of the physician of the condition of the patient.
9. The Licensee shall within thirty (30) days of the effective date of this Consent Agreement in-service all direct service staff on topics relevant to provisions of Sections 6, 7 and 8 of this document. The Licensee shall maintain an attendance roster of all in-service presentations which shall be available to the Department for a period of two (2) years.
10. In accordance with the following schedule for each Patient Service Office, which commences upon execution of this Consent Agreement, the Licensee shall audit the medical record of each patient currently receiving services to ensure that each patient's current condition is accurately and consistently documented and that care is provided in accordance with the plan of care. The completion schedule is as follows:
    a. Waterbury Patient Service Office completed within eight (8) weeks of the effective date of this Consent Agreement;
    b. Danbury Patient Service Office completed within eight (8) weeks of the effective date of this Consent Agreement;
    c. Trumbull Patient Service Office completed within eleven (11) weeks of the effective date of this Consent Agreement;
    d. Norwalk Patient Service Office completed within eleven (11) weeks of the effective date of this Consent Agreement;
    e. New Haven Patient Service Office completed within sixteen (16) weeks of the effective date of this Consent Agreement;
    f. Newington Patient Service Office completed within twenty-four (24) weeks of the effective date of this Consent Agreement.

11. Within ten (10) days after each completion dated specified above for the medical record audits, all direct care staff shall be provided with in-service education pursuant to deficient practices identified as a result of the medical record audits. Subject to this Consent Agreement, documentation of in-services shall be maintained by the Licensee for review by the Department for a period of two (2) years.
12. The Licensee upon the execution of this consent agreement shall pay a financial penalty of five hundred dollars ($500.00) to the Department. Said payment shall be received by the Department of Public Health no later than two (2) weeks after the effective date of this Consent Agreement. The check shall be made payable to the Treasurer of the State of Connecticut.
13. The financial penalty and any other reports required by this Consent Agreement shall be directed to:

Victoria V. Carlson, R.N., M.B.A.
Supervising Nurse Consultant, Department of Public Health,
Division of Health Systems Regulation
410 Capitol Avenue, MS #12 HSR
P.O. Box 340308
Hartford, CT 06134-0308

14. The provisions of this Consent Agreement shall remain in effect for a period of two (2) years from the effective date of this document. After this Consent Agreement has been in effect for one (1) year, Licensee may request that the Department agree to terminate the Consent Agreement prior to the end of the two-year term.
15. The execution of this document has no bearing on any criminal liability without the written consent of the Director of MFCU or the Bureau Chief of the DCJ's Statewide Prosecution Bureau.

16. The Licensee understands legal notice of any action shall be deemed sufficient if sent to the Licensee's last known address of record reported to the Division of Health Systems Regulation.
17. All parties agree that this Consent Agreement is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of this document or of any other statutory or regulatory requirements. This Consent Agreement may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Department may petition any court with proper jurisdiction for enforcement of this Consent Agreement in the event the Licensee fails to comply with its terms. .
18. The Licensee has had the opportunity to consult with an attorney prior to signing this document
19. The Licensee understands this Consent Agreement is effective upon approval and acceptance by the Commissioner's representative, at which time it shall become final and an order of the Commissioner of Public Health.

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IN WITNESS WHEREOF, the parties hereto have caused this Consent Agreement to be executed by their respective officers and officials, which Consent Agreement is to be effective as of the later of the two dates noted below.

PRIORITY CARE, INC. OF NEW HAVEN, CT.

7/20/04
Date

By: _____, President
Arthur Stratton, President

State of New Jersey)
County of Essex) ss July 20, 2004

Personally appeared the above named ARTHUR STRATTON, Pres and made oath to the truth of the statements contained herein.

My Commission Expires: July 30, 2008

Kevin G. Rogers
Notary Public [✓]
Justice of the Peace [ ]
Town Clerk [ ]
Commissioner of the Superior Court [ ]

KEVIN G. ROGERS
NOTARY PUBLIC OF NEW JERSEY
MY COMMISSION EXPIRES JULY 30, 2008

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

7/26/04
Date

By: _____
Marianne Horn, R.N., J.D., Director
Division of Health Systems Regulation

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT B

November 18, 2005

Lee Tyburski, RN, Administrator
Patient Care
1 Church Street, 5th Floor
New Haven, CT 06510-3342

Dear Ms. Tyburski:

Unannounced visits were made to Patient Care on September 29, October 3, 4, 7, 11, 12, 13, 2005 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a survey inspection with additional information received through November 16, 2005.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

An office conference has been scheduled for December 2, 2005 at 10 AM in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Victoria V. Carlson RN

Victoria V, Carlson, RN, MBA
Supervising Nurse Consultant
Facility Licensing and Investigations Section

SNC:VVC

c. Nurse Consultant

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

DATE(S) OF VISIT: September 29, October 3, 4, 7, 11, 12, 13, 2005 with additional information received through November 16, 2005.

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68 (b)(4)(A) General requirements.

1. The governing authority failed to assume responsibility for the services provided by the agency and to ensure the safety and quality of care rendered to Patient #s 1-23 and their families based on the violatioans listed in this docuemnt.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68 (d)(2) General requirements.

2. The administrator failed to organize and direct the agency's ongoing functions and to ensure the safety and quality of care rendered to Patient #s 1-23 and their families based on the violations listed in this document.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D68 (e)(2)(3)(A)(B) General requirements.

3. The supervisor of clinical services failed to assume responsibility for maintaining the quality of clinical services rendered to patients and families by direct service staff as evidenced by the care and services rendered to Patient #s 1-23 based on the violations listed in this document.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69 (a)(2) Services.

4. Based on clinical record review, narcotic register review, medication policy review, observation and staff interviews it was determined that for three (3) of seven (7) patients the nurse failed to furnish specialized nursing skill to document inclusion of all pertinent information to identify specific medications that had been administered and/or pre-poured (Patient #s 13, 14, 17). The findings include:

a. Patient #13's start of care date was 6/22/05 with diagnosis including schizophrenic disorder and drug dependency. Documentation on the certification plan of care dated 6/22/05 ordered skilled nursing services 7x per week to assess mental status, behavior, impulsivity, medication compliance, to pre-pour and/or to administer medications. Ordered medication included Zydis 20 mg daily and Topomax 25 mg daily. During a joint visit with RN #4 on 10/3/05 the surveyor observed that RN #4 told the surveyor that he was administering Zydis and Topomax to the patient, but failed to document the administration. Upon surveyor inquiry RN #4 stated that he signs the medication administration register in his vehicle after the nursing visit. Review of agency policies determined that there was no policy for

documentation of medication administration at the time the medications are given.

b. Patient #14's start of care date was 4/28/05. Documentation on the certification plan of care dated 4/28/05 to 6/26/05 and the re-certification plans of care dated 6/27/05 to 8/25/05 and 8/26/05 to 10/24/05 ordered skilled nurse 5-7 days per week to administer morning medications, to pre-pour evening medications and to assess mental status, and compliance with laboratory tests and treatments. Ordered medications included Zyprexa, Zydis wafer 15 mg twice daily, Klonopin 0.5 mg at hour of sleep and Prevacid 30 mg each morning. Documentation on a controlled drug count sheet dated 8/16/05 determined that the agency received 30 Klonopin tablets on 8/16/05, but that none were administered and/or pre-poured. Clinical record documentation on a 60-day summary to the physician dated 8/23/05 identified that Patient #14 reported compliance with evening medication and on 8/26/05 RN #7 identified that the patient expressed that she needed to take Klonopin because she awakens during the nights. During the period from 8/26/05 to 9/25/05 documentation by agency nurses on the nurse visit notes and the Medication Administration Record (MAR) consistently identified that the patient was compliant with administered and/or pre-poured medications.
When interviewed on 10/4/05, SCS #2 stated that the patient refused to take Klonopin daily as ordered, but prefers to use it as needed. When the drug was pre-poured it was taken from a supply that was kept in the patient's lock-box and excess Klonopin was kept in the agency. SCS #2 stated that RN #7 failed to document that the patient was not taking the drug as ordered and/or that that she reported this information to the physician.

c. Patient #17's start of care date was 1/20/04 with diagnoses including schizoaffective disorder and hypothyroidism. Documentation on the re-certification plan of care dated 9/11/05 to 11/09/05 ordered skilled nursing services 14 x per week to administer morning and evening medications daily, administer Risperdal injection weekly, assess mental status, management of behavior/impulsivity and to teach disease process, associated care and treatment, medication regimen and signs and symptoms of complications necessitating medical attention. Ordered medications included Synthroid, Risperdal Consta injection, Seroquel and Risperdal oral tablets. Clinical record documentation indicated that during the period from 10/1/05 to 10/4/05 agency nurses regularly administered medications, however there was no consistent documentation to indicate the specific medications and/or doses that were administered.
When interviewed on 10/5/05 RN #6 stated that she shares this case with other nurses. The Medication Administration Record (MAR) is kept in the agency's medication room with the patient's medications. Prior to visiting the patient, agency nurses pre-pour the medications at the agency, administer the medications to the patient in her home and sign the MAR when they return to the agency, which is not necessarily the same day. RN #6 stated that the MAR was not signed for October 1, 2, 3, & 4 because the nurse's who administered the medications had not yet returned to the agency as of 10/5/05.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69 (a)(3)(A) Services.

DATE(S) OF VISIT: September 29, October 3, 4, 7, 11, 12, 13, 2005 with additional information received through November 16, 2005.

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

5. Based on clinical record review, staff interviews, home visit observation and agency policy, it was determined that for Patient #11 the nurse failed to initiate a plan of care in a timely manner following a nursing assessment for a patient with a decubitus ulcer. The findings include:

a. Patient #11 was referred on 8/25/05 by the home care agency's "sister" homemaker-home health aide agency, which was providing a 24-hour live-in aide for the patient. The patient's live-in aide reported to her supervisor on 8/24/05 that a small pressure ulcer was developing on the patient's right hip approximately a quarter sized with a very small open area in the center; the area was draining scant, clear, serous fluid. The patient was to be referred to the home care agency for skilled nursing. On 8/25/05 the live-in aide reported to her supervisor at the homemaker-home health aide agency that there was no acute changes in the wound condition, the wound was red and weeping; the manager of the homemaker-home health aide agency felt the information was sufficient to refer the patient for skilled nursing services and a referral was initiated to the home health agency.
Review of the patient's clinical record at the home care agency identified the patient's start of care date as 9/21/05, however, an interagency referral form from the wound care center was dated.9/8/05.
Upon surveyor inquiry, Supervisor of Clinical Services (SCS) #3 stated that the patient was initially assessed by home care RN #9 on 8/26/05 but was not admitted to the agency due to the inability to obtain physician orders. Documentation of the initial skilled nursing assessment of 8/26/05 was received following surveyor's request. Review of the documentation of the initial assessment visit of 8/26/05 noted only that the patient had a right hip ulcer stage 3, measuring 2 x 2.5, she was not taking any medications, she had a 24-hour aide and her mobility was identified as wheelchair to bed. The initial visit lacked documentation regarding the description of the wound, VS, nutritional status etc. An OASIS initial comprehensive assessment was not completed.
RN #9 stated on 10/3/05 that she assessed the patient on 8/26/05 and called the physician who stated the patient needed to be seen by a physician before he would sign orders. The nurse called the patient's son and encouraged him to take the patient to the physician's office. RN #9 wrote an addendum note on 10/12/05 for the initial assessment of 8/26/05 which stated that the patient had a stage 2-3 right hip wound which measured 2 cm.x 2.5 cm, no depth, was pink in color and draining clear fluid. She stated that she called the physician who stated that another physician was supposed to see the patient. The nurse then called the other physician who stated that the patient needed to make an appointment with him to be seen in his office or go to the wound care clinic or the emergency room. The patient's caregiver and family were aware and the patient was not admitted at that time until orders were obtained. The clinical record lacked documentation to support that the agency called the patient and/or followed through with the family and/or physician in order to have the patient assessed and wound cared provided from 8/26/05 to 9/21/05. The agency failed to admit a patient and initiate a safe care plan for a patient who exhibited a stage 2-3 decubitus ulcer of the right hip and/or to send a bed bound patient to the emergency room for an accurate assessment of a stage 3 decubitus ulcer and plans for care to the wound. The patient was not admitted to the agency until 9/21/05 although the interagency referral form from the wound care clinic was dated 9/8/05. The patient's skin integrity had deteriorated since the initial visit of 8/26/05. Review of the homemaker-home health aide agency (H-HHAA)

supervisor's note dated 9/20/05 noted that the patient now exhibited a second decubitus ulcer on her spine and tegaderm was applied. The H-HHAA supervisor again notified the home care agency to admit the patient for skilled services.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69 (a)(3)(C) Services.

6. Based on clinical record review, policy review, staff interviews and interviews with other agencies involved in the patient's care and home visit observations it was determined that for four (4) of twenty five (25) patients the nurse failed to coordinate services and/or to maintain liaisons with all persons/entities involved in the patient's care (Patient #s 6, 11, 12, 23). The findings include:

a. Patient #6: On 09/20/05 PT #1 documented the patient's weight as 112.5 pounds; on 09/22/05 the patient weighed 105 pounds; on 09/27/05 the patient complained of gout in her toes at night at a pain level of six. There was no clinical record documentation PT #1 informed the primary care nurse, RN #2, of the patient's weight loss and complaint of gout. On 09/29/05 PT #1 documented he left a voice mail for RN #2 that the patient was still losing weight; PT #1 did not obtain a weight on 09/29/05. When interviewed on 10/13/05, PT #1 stated he probably talked to the SALSA at the managed residential community (MRC) concerning the weight loss; although the patient did not receive ALSA services, PT #1 stated the SALSA tries to know all the residents at the MRC. Interview with the SALSA on 10/27/05, she stated PT #1 did not tell her about the patient's weight loss.
When interviewed on 10/13/05, Therapy Supervisor #1 stated she did not know the patient was losing weight; that the patient experienced gout pain at night in her toes; if PT #1 informed the primary care nurse of the weight loss or gout. Therapy Supervisor #1 stated she was new to the agency as of 08/08/05; did not know all the therapy patients; nor did she routinely read the therapists notes.
Review of agency policy concerning coordination of care identified that care coordination will include, but not be limited to, regularly occurring communication or case conferences as needed and there will be written evidence of care coordination whenever there are patient status changes. PT #1 failed to communicate with the primary care nurse, RN #2 and/or Therapy Supervisor #1, concerning the patient's progressive weight loss and complaint of gout.

b. Patient #11 was referred to the home health care agency on 8/25/05 by the home care agency's "sister" homemaker-home health aide agency, which was providing a 24-hour live-in aide for the patient. The patient's live-in aide reported to her supervisor on 8/24/05 that a small pressure ulcer was developing on the patient's right hip approximately a quarter sized with a very small open area in the center; the area was draining scant clear serous fluid; the patient was to be referred to the home care agency for skilled nursing. On 8/25/05 the live-in aide reported to her supervisor at the homemaker-home health aide agency that there was no acute changes in the wound condition, the wound was red and weeping; the manager of the homemaker-home health aide agency felt the information was sufficient to refer the patient for skilled nursing services and a referral was initiated to

DATE(S) OF VISIT: September 29, October 3, 4, 7, 11, 12, 13, 2005 with additional information received through November 16, 2005.

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

the home health agency.
Review of the patient's clinical record at the home care agency identified the patient's start of care date as 9/21/05, however the interagency referral form from the wound care center was dated.9/8/05.
Upon surveyor inquiry, SCS #3 stated that the patient was initially assessed by home care RN #9 on 8/26/05 but was not admitted to the agency due to the inability to obtain physician orders; documentation of the initial skilled nursing assessment of 8/26/05 was received following surveyor's request. Review of the documentation of the initial assessment visit of 8/26/05 noted only that the patient had a right hip ulcer, stage 3 measuring 2 x 2.5.
RN #9 stated on 10/3/05 that she assessed the patient on 8/26/05 and called the physician who stated the patient needed to be seen by a physician before he would sign orders. The nurse called the patient's son and encouraged him to take the patient to the physician's office. RN #9 wrote an addendum note on 10/12/05 for the initial assessment of 8/26/05 which stated that the patient had a stage 2-3 right .hip wound which measured 2 cm.x 2.5 cm, no depth, was pink in color and draining clear fluid. She stated that she called the physician who stated that another physician was supposed to see the patient. The nurse then called the other physician who stated that the patient needed to make an appointment with him to be seen in his office or go to the wound care clinic or the emergency room. The patient's caregiver and family were aware and the patient was not admitted at that time until orders were obtained.
Review of the homemaker-home health aide agency nursing notes from 8/25/05 to 10/14/05 indicated that the patient was referred to the home care agency on 8/25/05 and would discuss the case following the skilled nursing visit by the home care nurse. The home health aide supervisor made another visit to the patient on 8/31/05 and noted that he called SCS #3 at the home care agency who stated that the patient was on hold and not admitted due to lack of orders and the agency would follow up after the patient was evaluated at the wound care clinic. The homemaker-home health aide (H-HHA) supervisor did not assess the patient again until 9/20/05 and noted that another decubitus was observed on the patient's spine and was a stage 3-4 with a smaller stage 1-2 spine decubitus and noted that the right hip decubitus no longer had eschar present and had progressed. The H-HHA supervisor stated skilled nursing was needed for observation and wound care as indicated. He called the wound care clinic, the patient's son, and physician and again to the home care agency to follow-up for skilled nursing.
Review of the home care agency's clinical record lacked documentation to support that the home care agency and/or RN #9 communicated with a physician, wound care clinic, patient's family and/or homemaker-home health aide agency after her initial visit on 8/26/05 when she did not admit the patient to the agency due to lack of orders. The agency/RN #9 failed to refer the patient to another agency per their admission policy and left Patient #11 at risk with a deteriorating wound status without skilled nursing care for 26 days from 8/26/05 to 9/21/05.
On 10/3/05 RN #9 stated that she encouraged the family to take the patient to a physician to have her wound evaluated.
The supervisor of clinical services stated on 10/12/05 that although the interagency referral form from the wound care clinic was dated 9/8/05 the home care agency did not receive it until 9/20/05.

c. Patient #12: Review of clinical record documentation dated 10/4/05 as an addendum to the skilled

nursing visit of 9/28/05 determined that the patient told LPN #2 that she had diarrhea the previous day, but there was no clinical record documentation to indicate that LPN #2 shared this information with RN # 8 (PCN) and/or the patient's physician. Agency nurses failed to communicate about the patient's status and failed to share information necessary to assure that safe, coordinated care was accessible to all persons involved in the patient's care.

d. Patient #23: Documentation by SCS #3 dated 8/20/05 on a case conference note faxed to the surveyor on 10/11/05 stated that RN #15 reported that the patient did not like the tube feeding and messages were left for the physician because he was difficult to contact. On the same conference note a second entry by SCS #3 dated 9/7/05 identified that RN #15 reported to SCS #3 that the patient refused to take Zoloft and RN #15 called the physician's office, but he was not available and a message was left. Review of clinical record documentation by RN #15 during the period from 9/7/05 to 9/29/05 determined the patient's nutritional status, functional status and/or state of depression progressively worsened, however there were no conferences with SCS #3 related to these issues.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D69 (a)(3)(D) Services.

7. Based on clinical record review, agency policy review, patient, physician and staff interviews and home visit observations it was determined that for six (6) of twenty five (25) patients the nurse failed to consistently and/or accurately assess and evaluate the patient's health status and nursing needs that may have suggested a need to alter the plan of care to ensure the safety of the patient at all times (Patient #s 6, 11, 12, 15, 22, 23). The findings include:

a. Patient #6 had a start of care of 09/17/05 with a principal diagnosis of digestive neoplasm and secondary diagnoses of large bowel resection with total colectomy (05/18/05), permanent colostomy, peri-rectal wound, stool positive for clostridium difficile (stool is loose and runny), bladder tumor with resection and indwelling Foley catheter, porta-catheter for chemotherapy, depression, osteoarthritis, cataracts, GERD, COPD, PVD, HTN and on 10/02/05 was positive for MRSA. This patient had a recent history of UTI, acute pancreatitis, cholecystectomy due to cholelithiasis (08/05), femoral bypass surgery and gout. The patient resided in a managed residential community but was not a recipient of ALSA services.

i. The certification and plan of treatment dated 9/17/05 to 11/15/05 ordered skilled nursing 3 times a week for 60 days for wound care, colostomy care as needed, change Foley catheter one time a month, flush porta-catheter one time a month, assess medication compliance and assess all body systems including mental status and medication compliance; home health aide was ordered three times a week for assistance with personal care, ADLs and light housekeeping; physical therapy was ordered 2 times a week for 60 days for gait training, endurance, transfers and ambulation; occupational therapy and medical social service evaluations were ordered. The certification and plan of care dated 09/17/05-11/15/05 was signed by RN #10, the care team manager for this case and by the wound clinic

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physician.
ii. The initial comprehensive assessment was conducted on 09/17/05 by RN #1. She documented the patient had limited ability to ambulate secondary to osteoarthritis, gout and decreased endurance; unsteady with walker; no reported feelings of depression though her mood was depressed; denies pain; 125 pounds with history of weight loss in 2005 due to illnesses and many surgeries per patient; goal was for weight to be maintained between 120 and 130 pounds; decrease in appetite; low sodium/regular diet; urine yellow in color with sufficient quantity; skin turgor good; skin pink; tires easily; presents with complex medical regime and some difficulty coping; overwhelming medical challenges; questionable family support as nieces/nephews and ill brother out of state; need for social worker due to altered body image, i.e. colostomy; need for nutritional consult; independent in dressing, toileting, light housekeeping; unable to do laundry; does not know how to change colostomy appliance; compliant with medications..
iii. On 09/18/05, RN #1 documented decreased, fair endurance; independent with walker; emotional status not documented; denies pain; weight not documented; appetite good; diet intake regular; sufficient fluid intake; urine yellow and clear; loose, brown stool; skin turgor fair; pale; medication compliance not documented.
On 09/19/05, LPN #1 documented endurance poor; uses walker independently; gait unsteady; appears weak; feeling depressed; denies pain; weight not documented; appetite poor; diet regular; encouraged to increase fluids; urine clear to amber; skin turgor fair. LPN #1 documented she reported her findings to RN #2, the primary care nurse and her care team manager, RN #3.
On 09/20/05, RN #13 documented endurance fair to poor; uses walker independently; coping well at present; denies pain; appetite fair; diet is three small meals; poor fluid intake, encouraged to increase fluids especially cranberry juice; clear, yellow urine; brown, soft liquid stool; skin turgor fair; pale.
On 09/20/05, RN #1 documented a telephone conversation with APRN #1 from the hospital wound clinic concerning the rectal wound care; APRN #1 told RN #1 to monitor the patient's nutrition. On 09/26/05, the primary care nurse, RN #2, received a facsimile from the wound care clinic with new wound care orders and a request for the nurse to monitor dietary intake.
On 09/21/05, the primary care nurse, RN #2, documented independent with walker; slightly anxious secondary to colostomy; denies pain; appetite slightly improved since returned home; increase fluid intake; clear, yellow urine; large amount of foul, liquid stool; home health aide oriented to the plan of care; skin turgor fair; report given to care team manager, RN #10.
On 09/26/05, LPN #1 documented fair endurance, reports getting stronger; appears depressed; pain off and on due to rectal wound but mostly when sitting up; appetite fair; regular diet intake; instructed to increase fluid intake; reviewed nutrition and hydration; skin turgor poor; compliant with medication schedule. LPN #1 documented she reported her findings to RN #2 and RN #3.
On 09/28/05 the primary care nurse, RN #2, documented endurance slightly improved from her visit on 09/21/05; independent with walker; anxious; appears to be overwhelmed with colostomy; in denial concerning ability to care for self; does not want to move to assisted living facility; denies pain; appetite fair to poor; question compliant with diet; instructed need to increase protein and fluid intake and monitor diet; appears to be losing weight; does not go down to dining room for meals; urine clear yellow without sediment; skin turgor fair; compliant with medication schedule. RN #2 called the

surgeon, Physician #2, inquiring about runny stools and odor from the stool (?clostridium difficile); should stool culture be obtained; when to discontinue indwelling Foley catheter; reported white areas on stoma and discharge from peri area; doctor's office gave patient a sooner appointment (date unknown).

On 09/30/05, LPN #1 documented endurance poor; unsteady on feet; independent with walker; appears very weak; had much difficulty getting off of chair and took several minutes to ambulate approximately fifteen feet from her chair to her bed; reports having a poor night; looked depressed; complains of pain at rectal wound area when sitting; appetite fair to poor; had only tea for breakfast; stated she would eat her lunch in the dining room; skips breakfast at times; diet is decreased sodium; fluid intake adequate per patient; urine light amber and slightly cloudy; Foley bag emptied at patient's request due to weakness; stool yellowish-brown, liquid; stool specimen obtained; skin turgor poor; pale; bilateral extremities dry; left index finger and left great toe, reddish and swollen, in much pain, history of gout; forgot to take Colchicine the previous day; reports she is compliant with all other medications. LPN #1 documented she reported her findings to RN #2 and RN #3. LPN #1 documented she called the patient in the pm; patient stated she had a good lunch, but it was brought to her in her room.

On 10/02/05, RN #1 documented endurance poor; not able to get out of chair; weak; in nightgown, disheveled; poor hygiene; positive odor from peri-area; appetite poor; diet and fluid intake not sufficient; has not eaten yet (10 AM); urine dark yellow; ostomy with foul smell; feces on multiple areas of bathroom; stool culture from 09/30/05 was positive for MRSA; appears to be confused; eyes sunken; poor skin turgor, tenting, dry; pale; orthostatic BP 90/50; apical pulse 68-100; left hand third finger large, reddened, gout; medications in plastic bag on medication cards from ECF, difficult to assess; RN #1 called the covering physician who ordered the patient be sent to the hospital via ambulance.

iv. PT #1 documented on his 09/20/05 initial evaluation the patient's weight as 112.5 pounds (using the health center's portable digital scale); fatigue, malaise, weakness; unsteady gait; decreased endurance. On 09/21/05, PT #1 documented the patient was still feeling tired, difficulty moving walker; PT ordered a gliding walker; no complaints of pain. On 09/22/05, at 2:45 pm, PT #1 documented the patient's weight was 105 pounds after lunch (using the health center's portable digital scale); no complaints. On 09/27/05, PT #1 documented the patient complained of pain in both side toes, gout related, hurts at night, better in daytime; toe pain at night is a 6 on a scale of 1 to 10; fatigued after short walking activity. On 09/29/05, PT #1 documented patient still loosing weight, though no weight documented. PT #1 documented on 09/29/05 he left a voice mail message for RN #2 that the patient was still losing weight.

Interview with PT #1 on 10/13/05, identified he probably talked to the SALSA at the MRC where the patient resided about the patient's weight loss and gout, not with the primary care nurse, RN #2. He stated during the 09/27/05 visit, he took off the patient's slippers and did not see any signs of gout. PT #1 stated he interpreted what the patient said about the gout to be a chronic condition that many elderly have; the patient's pain was at night; the gout and pain didn't effect her ambulation when he visited.

Interview with the SALSA on 10/27/05, identified she did not know PT #1 used the health center's scale to weigh the patient nor did PT #1 tell her the patient was losing weight.

v. On 09/30/05, the surveyor accompanied LPN #1 for the home visit. During the visit the patient

reported it took hours to remove her slacks before sleep last night due to weakness. The patient stated she was depressed. LPN #1 identified the patient's left index finger to be reddish and swollen; gout had flared up. The surveyor observed the patient's right great toe to be swollen, bright red and very tender to touch, especially when LPN #1 removed and put the patient's sock and shoe back on. The patient stated she had a high tolerance for pain however the gout pain was very bad. Upon leaving the patient's residence, LPN #1 reminded the patient to take the Colchicine for her left index finger gout. The surveyor noted the Colchicine was also for her right great toe. LPN #1 stated she was not aware of any great toe swelling and redness. LPN #1 re-examined the patient's feet and identified the signs and symptoms indicative of gout; LPN #1 documented the patient had a flair-up of gout in her left index finger and "left great toe". LPN #1 told the surveyor the patient would be seen again on Monday, 10/03/05. Branch Director #1 stated the patient would be seen over the weekend; that a medical social worker would be visiting that afternoon; and that she was not aware of the severity of the patient's condition until the surveyor discussed her status.

vi. Interview with SCS #1 on 09/30/05, identified she was not aware of the complexity of the case; that the patient was deteriorating; that medical social service had not been initiated; that RN #2 did not feel the patient needed MSW intervention; that it was the weekend nurse, RN #1 who initiated the MSW referral on 09/19/05; that a nutritional consultant had not been contacted.

Interview with RN #3 (LPN #1's care team manager) on 09/30/05, identified LPN #1 gives her report when there are abnormalities. RN #3 stated she was not aware that a MSW referral had been made but not instituted; that the patient was in need of a nutritional consultation; and/or the complexity of the case.

Interview with the agency administrator on 10/24/05, identified the failure to implement medical social work and occupational therapy was due to a system failure. Interview with the branch assistant director on 10/24/05, identified RN #1 did not follow-up on her assessment for a nutritional consultation for the patient; she is a new homecare nurse and wasn't clear how to go about doing that.

Interview on 10/25/05 with RN #10, the care team manager for RN #1 and RN #2, identified that at the end of the day, all the nurses who visited this patient gave her report. Their reports did not indicate the case was complex and that the patient's condition was declining. RN #10 stated that although the patient's plan of care was complex, she decided a LPN could regularly be involved in this case. RN #10 stated she obviously wasn't as on top of this case as she should have been; it was an error in her judgment not to be involved.

vii. Interview on 10/26/05 with APRN #1 at the wound care clinic, identified RN #1 called on 09/19/05 to discuss decreasing nursing visits from everyday to three times a week for wound care. APRN #1 stated she told RN #1 of the necessity to monitor the patient's intake and output of fluid and calories; with the patient's loose stool, draining rectal wound and bladder tumor, it was important to measure the patient's input and output (I & O). APRN #1 stated the patient was seen at the wound clinic on 09/26/05 by her associate, another APRN; my colleague and I collaborated on this case. The wound care treatment was changed. We were concerned about her I & O and decreased caloric consumption; she was only eating at about fifty percent. The patient didn't look good, but her lab results came back OK. The patient was to return to us one week later; our dietician was to see her. On 09/26/05 we faxed new wound orders to the home health care agency; which included for the nurse to

monitor her dietary intake. We never received any information from the home care nurses concerning the patient's caloric intake and/or her I & O. APRN #1 stated she did not know the patient had expired. During interview on 10/26/05 Physician #1, the patient's primary care physician, stated that on 09/30/05 the homecare nurse called and left a message saying the patient was weak and there were two areas of gout. He stated that was the first call he had received from a homecare nurse in several months. He was not told the patient was getting progressively weaker and/or that she was not eating or drinking well. Physician #1 stated the gout exacerbation was probably due to the patient's poor fluid intake. Physician #1 was not aware that the homecare nurse did not inform the patient to increase the Colchicine.

During interview on 10/27/05, SALSA #1 stated the patient never went to the dining room to eat since returning to her apartment on 09/16/05; she did purchase some lunches that were brought to her room; the last lunch purchased by the patient was on 09/28/05; all dinner meals were brought to her room. SALSA #1 stated earlier today (10/27/05) she learned from another resident who was friendly with the patient, that on 09/28/05, the last time the friend visited with the patient, there were five untouched dinner meals in the patient's refrigerator. The friend did not inform SALSA #1 of that.

viii. Review of PT #1's discharge summary written on 10/14/05 and received by the surveyor on 10/26/05, identified the patient died in the hospital with acute GI cancer metastasis. Review of RN #2's discharge summary written on 10/04/05, identified the patient was sent to the ER secondary to increased weakness and weight loss; C-difficile unresolved with new diagnosis of MRSA; unable to maintain safety, needs physician workup. RN #2 documented she called the surgeon, Physician #2 to inform him of the hospitalization.

ix. Review of the hospital medical record stated the patient was admitted on 10/2/05 with acute renal failure (ARF) secondary to dehydration, a UTI secondary to metabolic acidosis and gout. The patient's chief complaint was she was not eating and feeling weak. The patient reported having had diarrhea for 2-3 weeks, fatigued, weight loss of about fifteen pounds since August. An abdominal CAT scan showed no renal obstruction or hepatic lesions and right colon inflammation suggesting colitis. Appropriate IV hydration was administered. Patient #6 subsequently expired on 10/12/05.

The RN failed to accurately assess and/or to monitor the patient's nutritional status, including what and how much the patient was eating, ability to cook and/or to obtain meals, weight, fluid intake and output to effectively intervene to implement measures focused at preventing severe dehydration. The RN also failed to identify that the patient's physical and emotional status had progressively deteriorated and/or to ensure that medical social service and occupational therapy services were instituted as ordered by the physician. The RN failed to alter the home health aide's plan of care to include assistance with meal preparation, encouragement of fluids and report to nurse her consumption and I & O. The LPN failed to regularly and/or accurately collect objective data concerning nutritional intake, weight, fluid intake and output, medication compliance and signs and symptoms of gout. The supervisor failed to properly supervise all nursing staff that delivered nursing care to this patient to ensure the quality of clinical care provided to Patient #6 to promote healing and maintaining the patient's safety at all times.

b. Patient #11 had a start of care date of 9/21/05 with diagnoses of chronic skin ulcer and arthropathy. The physician's plan of care dated 9/21/05 included skilled nursing 7x a week for 9 weeks to assess VS,

all body systems, wound care, CP and mental statuses. The summary to the physician of 9/21/05 stated that the nurse would assess the patient's mobility, nutrition/hydration. The patient lived alone with a 24-hour aide, required total care, was alert/oriented with occasional forgetfulness/confusion and presently required wound care daily to the right hip. Wound care consisted of NS, followed by panafil and a 4 x 4 daily.

The 9/21/05 admission OASIS/comprehensive assessment indicated that the right hip decubitus ulcer was 2.5 x 2.0, a stage 3-4, without drainage but with a moderate odor. The patient was on a regular puree diet; mouth condition was WNL and was identified as having a good nutritional status. A nutritional supplement was not listed. The patient was dependent for all ADLs and IADLs and was a transfer bed to chair and wheelchair.

i. Review of the clinical record noted a 9/8/05 interagency referral form from a hospital's wound center which indicated that the patient had a stage 3-4 ulcer on the right hip and decubiti ulcers x 3 on the spine. The clinical record lacked documentation that the nurse identified the decubiti on the patient's spine. The secondary diagnosis listed on the referral form was caloric/protein malnutrition although the OASIS/assessment identified the patient as having a good nutritional status. Upon surveyor inquiry regarding the delay in service SCS #3 stated on 10/11/05 that the patient was initially referred by the H-HAA agency on 8/26/05 but the patient's physician would not sign orders until the physician or wound care clinic saw the patient. She stated that the 9/8/05 interagency referral form was not received by the agency on 9/8/05. Upon surveyor inquiry on 10/11/05 RN #9 sent addendums explaining the sequence of events from 8/26/05 to 9/21/05, which were lacking in the clinical record. See Tag G173.

ii. Review of the clinical record from 9/22/05 to 9/29/05 lacked documentation regarding wound measurements and/or description of the wound and/or mention of the wound on the patient's spine until the visit note of 9/27/05 when the nurse noted "ns, panafil to right hip and spine". The clinical record lacked documentation regarding any measurements, description and/or staging of the spine decubiti. Subsequent to surveyor inquiry on 10/12/05 an addendum was written by RN #9 on 10/12/05 for visit the of 9/21/05 which indicated that the patient had one spine wound which included measurements and a description, however the referral from the wound care center indicated that the patient had 3 areas on her spine which the nurse did not identify. The daily nursing notes from 9/21/05 to 9/29/05 indicated that the patient she took prn medication for pain, nutritional status was good, family visited time to time, the patient was total care with an aide who assisted with ADLs and IADLs. The clinical record lacked documentation regarding the patient's mobility, frequency and/or regime used to transfer the patient out of the bed, frequency of position changes, devices on the bed and/or chair to prevent further skin breakdown; lacked documentation quantifying the patient's nutritional status and/or use of a nutritional substitute since the wound care center identified a diagnosis of malnutrition on the 9/8/05 referral form and/or lacked clarification with the physician regarding nutritional interventions..

The nursing visit note visit of 9/29/05 noted that the nurse visited to assess the wound care and teach the family and the patient/caregiver to provide wound care. Subsequent to surveyor inquiry on 10/12/05 RN #9 wrote an addendum on 10/12/05 for the nursing notes of 9/22/05 and 9/23/05 which stated that she instructed the aide to change the patient's position side to side every 2 hours and that the patient had a hospital bed and an air mattress. She stated that she instructed the aide regarding the importance of good nutrition and encouraged more protein. A case coordination note of 9/29/05 with SCS #3 noted

that the family received instruction by the nurse to provide wound care daily and the son agreed to do the wound care daily and the nurse would visit 1x a week.
ii. The subsequent nursing visit was conducted on 10/3/05 with the surveyor present. The patient appeared alert and oriented, was sitting on her back in a hospital bed with an air mattress in place. A recliner, without a seat cushion, was noted next to the bed. The 24-hour aide stated that the patient was on a soft or pureed diet due to lack of teeth and/or dentures (although the OASIS/assessment of 9/21/05 stated that the patient's mouth was WNL). She reported to the nurse that the patient had a new skin breakdown on her coccyx area. RN #9 cleansed the decubitus and applied a dry dressing .The aide stated that the patient was not getting out of bed to the recliner (and not the wheelchair as noted in the initial assessment) very often due to back pain. The nursing notes of 9/21/05 to 9/29/05 lacked documentation to support that the nurse was aware and/or assessed the patient's back pain, which was preventing the patient from getting out of bed. Review of the case conference/coordination of care form dated 10/3/05 for the 10/3/05 visit noted that the patient's skin was fragile and that another wound appeared on her left buttocks measuring 1.5 x 1.0 and a dry dressing was applied, the physician was aware and she would see the physician in 2 days. RN #9 instructed the aide to turn the patient every 2 hours but the note lacked documentation to support that the nurse assessed the aide's compliance with the plan of care and/or quantified the patient's nutritional status and/or changed the plan of care in response to a deterioration of her skin integrity. The nurse did not visit the patient again until 10/7/05 and noted on her visit note that she taught the 24-hour aide to apply the panafil to right hip and apply tegaderm to the left buttocks and spine. The case conference note of 10/7/05 noted that the patient was seen at the wound care center and a new order for duoderm q 3 days to the spine and buttocks was initiated and the nurse instructed the family and aide regarding this treatment and the nurse would visit 1-2x a week. The patient's son stated on 10/19/05 that he never performed wound care as indicated in the patient's clinical record.
Review of the clinical record from 9/21/05 to 10/7/05 indicated that Patient #11 lived alone with a 24-hour live-in aide, was alert and oriented but forgetful, was total care and non ambulatory and exhibited a deterioration in her skin integrity. The clinical record lacked documentation to support that the nurse referred the patient for physical therapy to assess her functional status and mobility and/or failed to refer for a social worker to assess for long term planning and community resources and/or failed to refer for home health aide hours under the Medicare benefit; the patient's son stated on 10/19/05 that the agency did not offer a home health aide under the Medicare benefit
The nurse failed to consistently and/or accurately assess and/or document the assessment of the patient's skin integrity, functional status/mobility/regime, nutritional status, the appropriateness of the live-in aide to perform wound care and failed to assess the patient's change in health status which would precipitate the need to refer for other services.

c. Patient #12's start of care date was 9/21/05 with diagnoses including postoperative infection, total hip replacement and osteoarthrosis. Documentation by RN #8 on the certification plan of care dated 9/21/05 to 11/19/05 ordered skilled nursing service 2 x wk x 1, 4 x wk x 1, 3 x wk x 7 weeks for wound vac/wound care, to assess signs and symptoms of complications, cardiovascular status and respiratory status; medications included Paxil, Percocet, Cefazolin, Klonopin, and multivitamins. Documentation

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by RN #8 on the initial summary to the physician dated 9/21/05 identified that this 43 year old patient was alert and oriented, but expressed anxiety. She underwent a total hip replacement on 7/7/05 with subsequent wound infection and incision and drainage was performed on 9/14/05. The left hip wound was 7cm long x 4cm wide x 10 cm deep. RN #8 identified that Patient #12 expressed multiple concerns including pain, anxiety, decreased mobility, and that her step-father had died 2 months earlier. Patient #12 lived with her spouse and was dependent for most home management tasks. RN #8 identified that the patient had a PICC line in her left arm (for antibiotic infusions) and the site was within normal limits. Documentation by RN #8 on the OASIS/comprehensive assessment dated 9/21/05 identified that a high protein diet was ordered, but the patient complained of a poor appetite. Documentation was lacking to support that the nurse assessed the patient's weight and/or nutritional risk, however a referral for dietician services was initiated. RN #8 documented that gastro-intestinal status was within normal limits.

Clinical record documentation determined that the patient was revisited on 9/22/05 by LPN #2, on 9/25 by RN #8 and on 9/28/05 by LPN #2; during that period appetite assessment was inconsistently completed and varied from poor to good, gastro-intestinal status was within normal limits, but there was no documentation to support that coping and/or the PICC line site was assessed.

On 10/6/05 the surveyor received documentation by LPN #2 dated 10/5/05 as an addendum note to 9/28/05 that identified that the patient complained of diarrhea occurring on 9/27/05 and planned to follow up with her physician. There was no clinical record documentation to support that LPN #2 reported this to the physician and/or to the PCN and/or that LPN #2 followed up with the patient in a timely manner.

Documentation by Registered Dietitian (RD) #1 dated 9/28/05 identified that Patient #12 expressed that she was trying to maintain a positive outlook despite the (medical/emotional) difficulties of the past summer months. Patient #12 reported that her appetite had been very poor and that after a few bites of foods she became nauseous and developed explosive diarrhea. A nutritional assessment note by RD #1 dated 9/28/05 that was addressed to the PCN identified that the patient had incurred an unintentional 20% weight loss that was further complicated by the extreme seriousness of her wound. RD #1 documented that she reported the patient's status to the physician and that labs were ordered to assess serum Albumin.

During a joint visit with RN #11 on 10/3/05, Patient #12 told the surveyor that she lost 48 pounds due to loss of appetite and consistent, intermittent diarrhea for the past 8 months. Patient #12 stated that when she tried to eat supper the previous evening, she spent the night walking the floor with abdominal cramping and frequent bouts of diarrhea. Patient #12 expressed sadness when talking about her stepfather's death and stated that supporting her mother's grief had been very difficult. Patient #12 also stated that she was also dealing with her daughter's marriage problems and that all of these issues were compounded by her confinement, poor endurance and her dependence on her spouse for managing the home. At he conclusion of the joint visit, Patient #12 requested that the nurse observe the PICC line site because it was red, inflamed and sore. After the visit, RN #11 told the surveyor that she did not previously know Patient #12 and that she had received report about the patient's wound from her supervisor, but that she was unaware that the patient was depressed and/or that she had weight loss and/or chronic diarrhea.

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When interviewed on 10/26/05 RN #12 (care team manager) stated that RD #1 delivered the nutritional assessment and her conclusions dated 9/28/05 to RN #8's mail box and that RD #1 did not verbally communicate the findings to the PCN. It was unclear when RN #8 received RD #1's report dated 9/28/05, but RN #12 documented on a report to the surveyor dated 10/26/05 that RN #8 communicated RD #1's findings to RN #12 and/or to the physician on 10/4/05. Review of agency policy determined that there was no policy for verbal reporting of case communications.

There was no clinical record documentation to determine the responsibility of caring for the PICC line. When interviewed on 10/4/05 RN #12 (care team manager) stated that the patient's PICC line was managed by an infusion company, but a memo of understanding was not obtained until 10/3/05 and RN #12 was unable to locate documentation to support that agency nurses had communicated with the infusion company. RN #12 stated that documentation could not be found to determine that agency nurses assessed the patient's PICC line site after the admission assessment. Review of agency policies determined that there was no policy for assessing infusion sites when another agency is responsible for the infusion medications and/or lines.

When interviewed on 10/4/05 RN #12 stated that agency nurse's spoke with Patient #12 often about the current emotional issues in her life, but failed to document their assessments of her coping status. On an undated patient update received by the surveyor on 10/4/05, RN #12 identified that a physician's order would be obtained for a medical social service evaluation to deal with the issues of ineffective coping and the patient's response to Paxil.

Agency nurses failed to accurately and appropriately re-evaluate and/or to document accurate re-evaluation of Patient #12's nutritional risk and/or current weight/weight history when she reported that her appetite was poor and/or failed to accurately assess her gastro-intestinal status after she reported diarrhea and/or failed to consistently and accurately assess the PICC line insertion site until Patient #12 complained of irritation and/or failed to assess Patient #12's mental health status and/or her possible need for medical social services when the patient related that she was grieving for the loss of a step-parent and/or failed to act in a timely manner to inform the physician of the patient's status that suggested the need to alter the plan of care.

d. Patient #15's start of care date was 4/5/02 with diagnoses including schizoaffective disorder and malignant hypertension. Documentation on the recertification plan of care dated 7/18/05 ordered skilled nurse visits 14 times per week to assess cardiovascular status, mental status, management of behavior/impulsivity, compliance with lab work, to administer morning medications, to pre-pour evening medications. Ordered medications included Inderal 20 mg twice daily; Artane 2 mg every morning, 4 mg at hour of sleep; Depakote 500 mg each morning, 1500 mg each evening; Zyprexa 30 mg at hour of sleep; Navane 30 mg at hour of sleep and Klonopin 1 mg twice daily. Documentation by RN #14 on the 60-day summary to the physician dated 7/18/05 identified that the patient continued to be nocturnal, sleeping all day and sometimes difficult to awaken for medications. Patient #15 was always cooperative, but withdrawn, guarded, very paranoid, disorganized and forgetful. During the period from 7/18/05 to 9/15/05 agency nurses visited the patient once daily to administer medications and to pre-pour evening medications for self administration. Assessments of the patient's mental status consistently identified that Patient #15 was alert and oriented, but his mental status included a flat

affect with guarded and withdrawn behavior. Patient #15 was forgetful, lacked insight and had impaired judgment and his thought processes were frequently delusional and fragmented. Documentation by RN #14 dated 8/19/05 identified that Patient #15 was confused with the medication pre-pour and on 8/27 and 8/30/05 agency nurses documented that the patient could not be aroused and medications were left for 24-hour self administration.

Documentation by RN #14 on 9/15/05 identified that the family complained because Patient #15 had kept all of them up the night before because he was louder than usual. RN #14 identified that Patient #15's mental status had not changed, that he was unengagable with poor eye contact and that he woke up, took his morning medications and went back to sleep. There was no documentation to indicate that agency nurses followed up that day when the patient would be more alert to re-assess his mental status and/or to assess why his behavior was changed the previous evening. Documentation on 9/16/05 by RN #14 stated that the family reported that the patient was admitted for emergent care due to increased signs and symptoms of psychosis and paranoia. When interviewed on 10/11/05 RN #14 stated that the patient did not demonstrate any symptoms of decompensation on the morning of 9/14/05.

During the period from 7/18/05 to 9/15/05 clinical record documentation was lacking to support that agency nurses consistently assessed the patient's compliance with self-medication and/or the times of day the patient was taking the pre-poured medications.

When interviewed on 10/11/05 RN #14 stated that she always checked with the patient's father to make sure that the medications were taken as ordered, but failed to document this information. RN #14 stated that the patient resisted nursing visits twice a day and she relied on the father to be aware of the necessity for medication compliance because he was also schizophrenic and shared the same psychosis as Patient #15.

When interviewed on 10/25/05 Physician #3 stated that the patient was not reliable to independently take his medications as ordered. Rather, he would nibble on them throughout the time that he was awake. Physician #3 stated that Patient #15 was hospitalized for two weeks because he decompensated because, by his own admission, he stopped taking his medications.

When interviewed on 10/26/05 the patient's clinical therapist stated that the patient's environment was unstable because his father and brother were both also afflicted with schizophrenia and if medications were left for Patient #15 to take, "he just would not take them." The therapist stated that after Patient #15 decompensated, multiple medications were found in the drawers of his bureau. Agency nurses failed to accurately and appropriately re-evaluate and/or failed to document accurate re-evaluation of the patient's compliance with the ordered medication regimen and/or failed to accurately assess the patient when the family reported a change in his behavior and/or failed to follow up in a timely manner to assess mental status when the patient was alert and/or failed to inform the physician of the change in status that suggested a need to alter the plan of care.

e. Patient #22 had a start of care date of 7/26/05 with diagnoses including dysthymia, diabetes chizophrenia, emphysema, congestive heart failure and hypertension. The plans of care dated 7/26/05 and 9/24/05 included skilled nursing 14 x a week to assess VS, all body systems, knowledge of disease processes, administer AM and PM medications and instruct the patient in need for AM weights, s/s of complications, diabetic care. The nurse identified parameters as to when the physician should be

notified regarding the patient's VS, weights and blood sugars. The home health aide was ordered 2 x a week to assist with the patient's personal care and IADLs. The summary to the physician dated 7/26/05 indicated that the patient was referred from a nursing facility following a fall at home. The patient was alert and oriented and had numerous psychiatric and medical issues. She lived alone and had a supportive daughter. On admission the patient exhibited anxiety, agitation with scattered thoughts and poor insight into her illness. The patient verbalized occasional shoulder pain since the fall.

i. The 7/26/05 and 9/24/05 plans of care included Humulin 70/30, 25 units sc in the AM and Humulin 70/30, 15 units sc in the PM. The patient was also on a sliding scale for regular insulin. Review of the clinical record from 7/26/05 to 10/2/05 indicated that the nurse administered the patient's insulin twice a day and the patient consistently needed the sliding scale regular insulin twice a day. Branch Director #1 stated on 10/13/05 that the nurse had communicated with the physician initially after the patient's discharge from the nursing home regarding the frequent use of regular insulin coverage and was told that he didn't want to change her insulin until she was adjusted to home. The clinical record lacked further re-evaluation of the possible need to adjust the patient's insulin due to the consistent use of regular insulin coverage and/or lacked communication with the physician to clarify the issue.

ii. The plans of care dated 7/26/05 and 9/24/05 included Darvocet N 100 mg. q 4 hrs prn for pain. Review of the clinical record from 7/26/05 to 10/3/05 indicated that the patient's pain in her left shoulder ranged from 0 to 10 and she continually complained of left shoulder pain. The clinical record lacked documentation to support that the nurse assessed the potential need for a daily pain medication instead of a prn medication, assessed the frequency and effect of the prn pain medication and/or documented if she pre-poured the Darvocet to be taken q 4 hrs as needed by the patient.

iii. The clinical record identified that the patient had a fractured left arm due to a fall at home and had limited mobility and pain in the left arm. The interagency referral form dated 7/26/05 from the nursing home referred the patient for occupational therapy; occupational therapy was not initiated by the nurse on admission. An order was sent to the physician on 8/16/05 for a physical therapy evaluation; physical therapy did not evaluate the patient until 9/8/05 (6 weeks after the patient was admitted to the agency). The director of nursing stated on 10/11/05 that only PT not OT evaluated the patient and that the delay in service was due to the agency's referral process.

iv. The patient was admitted to the home care agency following discharge from a nursing home on 7/26/05 after a fall in the home. The admission OASIS/comprehensive assessment of 7/26/05 indicated that the patient was homebound. The 7/26/05 summary to the physician stated that the patient had a recent diagnosis of congestive heart failure. The plan of care of 7/26/05 indicated that patient was to be weighed daily, was on insulin twice a day with a sliding scale, was forgetful, anxious, agitated and non-compliant with medications and was on oxygen 2 liters via nasal cannula. Review of the clinical record from 7/26/05 indicated that the patient's diabetic status, pain management and CP status were unstable and the patient needed PT for safety and mobility. The nurse documented every visit that the patient was not homebound although the patient did not leave the home. The nurse failed to assess the patient as eligible for Medicare and utilized Medicaid as the primary payor source. RN #5 stated on 10/11/05 that because the patient needed daily medication administration and pre-pours, she did not identify Medicare as the primary payor source. She failed to assess the patient's unstable medical status as a primary reason for skilled nursing and therapy services.

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The nurse failed to accurately and/or consistently reassess the patient's unstable diabetic status, pain management, functional status and need for physical therapy and Medicare eligibility.

f. Patient #23's start of care date was 8/2/05 with diagnoses including postoperative infection, malignant neoplasm of the stomach and hypovolemia. Documentation on the interagency referral report dated 8/1/05 stated that the patient had a history of borderline diabetes and that she had a jejunostomy (J-tube), but had been unable to tolerate feedings through the J-tube. Documentation on the certification plan of care dated 8/2/05 to 9/30/05 ordered skilled nurse 5-7 times per week to assess vital signs, mental status, general body systems, knowledge of disease process and care, medication regimen and weekly weights; perform/flush J-tube with 30 cc water daily. Ordered medications included Augmentin, Lovenox, Diovan, multivitamins, Coumadin, Reglan, Metoprolol, Nystatin and Oxycodone.
Documentation by RN #15 dated 8/2/05 on the 10-day summary to the physician stated that the skilled nurse would monitor nutrition and blood pressure, assess weights each visit and administer Lovenox injection daily. On the summary dated 8/2/05 RN #15 identified that Patient #23 was weak, had nausea and vomiting and was very worried because she could no longer manage her home. Documentation by RN #15 on the OASIS/comprehensive assessment dated 8/2/05 identified that this 56-year old patient was alert, but that she had daily anxiety. Patient #23 depended on her spouse's assistance for most activities of daily living (ADLs) and instrumental activities of daily living (IADLs). A regular diet was ordered with Ensure supplements and the patient had a jejunostomy tube. Documentation was lacking to indicate if a tube feeding was ordered and/or to support that the nurse performed a comprehensive assessment of the patient's nutritional risk, gastro-intestinal function and/or skin integrity around the jejunostomy tube and/or the porta-cath site. Patient #23 weighed 123 pounds.
During the period from 8/2/05 to 8/19/05 RN #15 consistently documented that the patient experienced frequent nausea and vomiting, refused to eat and/or was eating minimally, and/or that her weight was not assessed. RN #15 documented that the patient was drinking, but did not indicate the amount. On 8/10/05 the patient told RN #15 that she received fluids at the physician's office; on that date RN #15 identified that the patient weighed 124 pounds, that she continued to be weak and was spending most of her time in bed and that she had minimal to no motivation to get out of bed. During that period (8/2/05 to 8/20/05) there was no clinical record documentation to support that RN #15 intervened to monitor the patient's intake and output, if she was taking supplements, to assess weights, and/or if the patient was using the Reglan three times per day.
On 8/19/05 RN #15 documented that the physician wanted Patient #23 to resume tube feedings at night. Patient #23 was sad and unhappy and she refused the tube feedings, was not eating and complained of gagging when brushing her teeth. During the period from 8/20/05 to 8/27/05 Patient #23 continued to refuse the tube feedings and RN #15 consistently identified that food intake was poor; nausea, vomiting and diarrhea occurred and that the patient was weak and refused to get out of bed; during that period there was no documentation to support that RN #15 informed the physician of the patient's status. On 8/26/05 RN #15 documented that the patient was going to the physician and the nurse would contact the physician after the appointment to discuss the plan of care, but there was no documentation to determine that this was done. On 8/27/05 RN #15 documented that the physician ordered the patient to have the tube feeding or go to the hospital; and the patient had the tube feeding done that night. During

the period from 8/27/05 to 9/29/05 RN #15 documented that the patient took the tube feedings intermittently and that she consistently complained of stomach soreness, nausea, vomiting and diarrhea and oral intake ranged from nothing to poor. On 9/7/05 RN #15 documented the patient's weight was 115 pounds and that the patient told her that the physician ordered a nutritional consult, but there was no clinical record documentation of a referral. Documentation was also lacking to support that the nurse assessed the tube feeding product, the volume or rate of the tube feedings, the frequency of the patient's use of Reglan and/or Compazine and responses to those medications and/or total intake and output and/or that the nurse communicated with the physician about these issues.

When interviewed on 10/11/05 RN #15 stated that the patient's weight was assessed frequently in the home and during the period from the start of care of 8/2/05 to 10/11/05 the patient's weight decreased from 125 pounds to 113 pounds. RN #15 acknowledged that this documentation was not in the clinical record and she stated that she kept ongoing notes about the phone calls to the physician's office in the "travel record" in her car. On 10/13/05 the surveyor received nurse's notes documented by RN #15 during the period from 8/12/05 to 10/3/05 that included several contacts with the physician's nurse with one discussion about the patient's poor nutritional status on 9/13/05. During the interview on 10/11/05 RN #15 stated that she did not communicate with the physician because he would not answer her calls, so that she left messages with his nurse. RN #15 stated that she conferred with SCS #3 about the patient at least twice and related that she had been unable to contact the physician.

Documentation by SCS #3 dated 9/9/05 identified that she contacted the physician's office and informed his nurse about the necessity that the physician speak to the home care nurse when she calls. The physician's office nurse stated that the physician gets all of his messages. When interviewed on 10/11/05 SCS #3 stated that she intended to seek a resolution to this problem by asking for the assistance of the professional advisory committee physician.

When interviewed on 10/28/05 RN #15 told the surveyor that the nutritionist consulted by telephone with the patient the week earlier. RN #15 stated that the nutritionist mailed the patient a diet plan, that RN #15 reviewed it with Patient #23, but the patient was not compliant with the diet. RN #15 stated that she left a message with the physician on 10/27/05 informing him that the patient was listless and very weak. RN #15 stated that the patient's weight was about 107 pounds on 10/28/05.

When interviewed on 10/28/05, Physician #4 stated that since August 2005 he had received some messages about the patient's non-compliance with the tube feeding and refusal for some services. Physician #4 stated that he had seen the patient in his office about six times since August and he was aware that she refused compliance with the treatment regime without meaningful reason. Physician #4 stated that this patient was not suitable for home health care because she requires 24-hour supervision to enable appropriate treatment.

Physician #4 stated that he had not heard from the home health agency at least within the past month. When informed of the report given to the surveyor on 10/28/05 by RN #15, the physician stated that the patient is probably dying from starvation because she refuses to be compliant with ordered diet, tube feedings and medications. The physician stated that he planned to call the patient.

Documentation by RN #15 on the OASIS/comprehensive assessment dated 8/2/05 stated that the patient had anxiety daily. On the 10-day summary to the physician, RN #15 documented that the patient had difficulty coping with her loss of ability to manage her home. During the period from 8/2/05 to

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9/29/05 RN #15 consistently documented that Patient #23 was depressed, that depression was deepening at times and that her spouse was very stressed about her decline and angry about her non-compliance with necessary oral intake and ordered tube feedings. During that period there was no clinical record documentation to support that RN #15 evaluated Patient #23 for medical social services and/or that she collaborated with a medical social worker and/or psychiatric nurse in order to intervene effectively and/or that the physician was informed of the deteriorating emotional status of the patient and/or her spouse.
When interviewed on 10/11/05 RN #15 stated that the patient refused social services and psychiatric nursing services and the physician was informed. RN #15 stated that she documented about this in the travel record that was in her car.
During the period from 8/2/05 RN #15 consistently documented that the patient was increasingly immobile and weak, however there was no documentation to support that physical therapy and/or occupational therapy services were offered. When interviewed on 10/11/05 RN #15 stated that the patient refused physical therapy and occupational therapy services, but that she did not inform the physician and she did not document this in the clinical record.
The nurse failed to accurately and appropriately re-evaluate and/or to document re-evaluation of the patient's nutritional status, weight loss, weakness and/or the patient's and/or caregiver's progressive depression and/or failed to intervene to change the plan of care to appropriately address these issues and/or failed to collaborate with the physician and/or other members of the health care team about the patient's status and/or possible referral of additional services.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D73 (b) Patient care plan.

8. Based on clinical record review, agency policy review, staff interviews and home visit observations it was determined that for three (3) of twenty-five (25) patients the nurse failed to follow the written plan of care/orders as established by the physician (Patient #s 1, 6, 15). The findings include:

a. Patient #1 had a start of care of 09/01/05 with a principal diagnosis of difficulty in walking and secondary diagnoses of abnormal gait, sprain in right lower extremity, convulsions, HTN, ASCVD, PAF, left CVA with right sided weakness and aphasia (onset unknown) and a CABG in 1993. Physical therapy was the only service ordered for two times a week for sixty days for gait training, transfer techniques, endurance improvement and improve strength; the certification and plan of care dated 09/01/05 - 10/30/05 was signed by Therapy Supervisor #1.
i. On admission PT #1 documented the patient's sitting blood pressure at rest to be 193/93. The patient's vital signs were not included on the initial summary to the physician. There was no clinical record documentation the physician was notified of the elevated blood pressure. There were no documented parameters as to what blood pressure range was acceptable for this patient. PT #1 documented he discussed with the SALSA his findings and the PT plan of care.
Interview with Therapy Supervisor #1 on 10/13/05, she stated she was new to home care, having started

on 08/08/05. She stated that if PT is the only skilled service involved, she reads the OASIS written by the therapist before she writes the certification and plan of care. Therapy Supervisor #1 stated she doesn't recollect seeing the elevated blood pressure reading on the OASIS. If PT #1 informed the physician about the elevated blood pressure, I would have expected him to document that conversation.

Interview with PT #1 on 10/13/05, he stated he was surprised the vital signs weren't included on the certification and plan of care. PT #1 stated on his first visit to a patient, their blood pressures tend to be elevated, as they are nervous and scared. He stated he consults with the SALSA after each initial visit and reviews every patient's blood pressures with the SALSA; all have been in normal limits. PT #1 stated he telephones the physician after each initial visit and tells all his findings. PT #1 stated he doesn't remember asking the physician if the elevated blood pressure was OK. PT #1 stated he didn't feel the need to tell Therapy Supervisor #1 about the blood pressure.
RPT #1 failed to inform the physician and/or confer with Therapy Supervisor #1 about the patient's elevated blood pressure and at what parameters should the physician be notified.

b. Patient #6 had a start of care of 09/17/05 with a principal diagnosis of digestive neoplasm and secondary diagnoses of large bowel resection with permanent colostomy, peri-rectal wound, stool positive for clostridium difficile (stool is loose and runny), bladder tumor with resection and indwelling Foley catheter, port-a-catheter, depression, osteoarthritis, cataracts, GERD, COPD, PVD, HTN and on 10/02/05 was positive for MRSA. This patient had a recent history of UTI, acute pancreatitis, gallstones with cholecystectomy, femoral bypass surgery and gout.
i. LPN #1 visited the patient the morning of 09/30/05. On 09/30/05, LPN #1 documented the patient had a flair-up of gout in her left index finger and left great toe. In the afternoon, LPN #1 documented she called the doctor's office and reported increased weakness, gout flair-up and the patient had not taken her Colchicine the previous night. LPN #1 received a call back from the doctor's office; the physician increased the Colchicine from 0.6mg every day to 0.6mg every four hours as needed. LPN #1 documented she researched the medication Colchicine in the Nurses Drug Handbook and decided the prescribed dose was too high. LPN #1 documented she called back the physician's office and spoke with the physician's receptionist requesting clarification of the new order; the receptionist stated the physician would call LPN #1 back later on 09/30/05. LPN #1 documented she would contact the physician's office again on Monday, 10/03/05 for clarification of the Colchicine order. LPN #1 did not call the patient to inform her of the physician's order to change the medication. On 10/03/05, LPN #1 called the physician's office and learned the patient had been hospitalized on 10/02/05 and the physician had wanted the patient to take Colchicine 0.6mg every four hours as needed for gout.
ii. Following her first telephone call to the physician's receptionist, LPN #1 documented she gave report to her care team manager, RN #3, the primary care nurse, RN #2 and the weekend nurse, RN #1. Interview with RN #3 on 10/13/05, she stated she did not know LPN #1 called the physician's office questioning the physician's order for the Colchicine, as she, RN #3 had left for the day. RN #3 stated she knew LPN #1 had called to report the patient's weakness and gout flair-up and wanted to know if there would be a change in medication.
iii. Review of agency policy pertaining to supervision of staff stated a registered nurse is available on

the premises or by telephone/electronic pager 24 hours a day, seven days a week at each branch office. LPN #1 failed to case conference with a supervisor prior to calling the physician concerning her questioning of the physician's order to increase the Colchicine 0.6mg to every four hours as needed. LPN #1 failed to ensure a nursing supervisor/or RN on duty would take the physician's call on 09/30/05 after she left for the day so that the physician's order could be followed.

c. Patient #15: Documentation by RN #14 on the recertification plan of care dated 7/18/05 to 9/15/05 determined that the physician ordered skilled nursing visits 14 x per week for medication administration. Documentation by RN #14 on the 60-day summary to the physician that was part of the recertification plan of care dated 7/18/05 identified that the nurse administered morning medications and pre-poured evening medications and assessed medication compliance. There was no documentation on the summary to indicate that the nurse was not present in the evening to assess the patient's compliance. Review of clinical record documentation by agency nurses during the period from 7/18/05 to 9/15/05 determined that they consistently documented that the patient was disorganized and forgetful, but visited the patient only one time per day. Also, there was no consistent documentation to support that agency nurses assessed medication compliance.

EXHIBIT C

DHSR Independent Nurse Consultant Guidelines

Relationship between Independent Nurse Consultant (INC) and DPH includes:

- An INC is utilized as a component of DPH's regulatory remedy process. An INC may be agreed upon as a part of a Consent Order between the institution and the Department when significant care and service issues are identified.
- The INC has a fiduciary or special relationship of trust, confidence and responsibility with the Department.
- The INC's responsibilities include:
  - Reporting to the Department issues and concerns regarding quality of care and services being provided by the institution.
  - Monitoring the institution's plan of correction to rectify deficiencies and violations of federal/state laws and regulations. Reports to Department positive and negative issues related to said oversight.
  - Assessing administration's ability to manage and the care/services being provided by staff.
  - Weekly reporting to the Department of issues identified, plans to address noncompliance and remediation efforts of the institution.

Relationship between INC and the Institution:

- The INC maintains a professional and objective relationship with the institutional staff. The INC is a consultant, not an employee of the institution. The INC exercises independent judgment and initiative to determine how to fully address and complete her/his responsibilities. The institution does not direct or supervise the INC but must cooperate with and respond to requests of the INC related to her fulfilling her/his duties.
- The INC's responsibilities include:
  - Assessment of staff in carrying out their roles of administration, supervision and education.
  - Assessment of institution's compliance with federal/state laws and regulations.
  - Recommendations to institutional administration regarding staff performance.
  - Monitoring of care/services being provided.
  - Assists staff with plans of action to enhance care and services within the institution.
  - Recommendation of staff changes based on observations and regulatory issues.
  - Weekly reports to the institution re: assessments, issues identified, and monitoring of plans of correction.
  - Promotes staff growth and accountability.
  - May present some inservices but primary function is to develop facility resources to function independently.
  - Educates staff regarding federal/state laws and regulations.